MEDICAL PRACTITIONERS UNION

ENTRY INTO PRACTICE

SPECIAL COMMITTEE REPORT

The Medical Practitioners' Union offers this report to the Medical Profession in the hope that it may help to solve some of the problems which beset all sections of the profession at the present time.

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MEDICAL PRACTITIONERS' UNION

REPORT ON ENTRY INTO PRACTICE

The Objects of the Report

There is widespread dissatisfaction throughout the profession with regard to the existing methods of (1) entering general medical practice in the National Health Service (2) entering consultant practice. The Council of the Medical Practitioners' Union has examined the present position with the object of determining whether some better method could not be devised to remedy the present unsatisfactory state of affairs.

The scope of the problem

This problem must be considered from two points of view, (1) from that of the Public and (2) from that of the doctor.

(1) The State has undertaken the duty of providing medical care and attention for the whole of the community. Medical manpower is limited; it is therefore necessary for the Minister to ensure that this manpower is available where most needed. It is not enough to have the right number of doctors for the country's population; these doctors must be evenly distributed. Under the old regime a district contained the number of doctors that its population could afford to support. Health resorts and the residential areas of the larger cities had one doctor to every thousand of the population, while in the industrial areas of the North and the mining villages of South Wales there was one doctor to every four thousand or over. The Minister, as guardian of the public's welfare, is therefore vitally concerned with the redistribution of medical manpower. No solution to these problems will satisfy if it does not lead, gradually but continuously, to such a redistribution.

(2) Although the general welfare must be paramount at all times, the problems considered in this Report are essentially those of the doctor. We are concerned not only with the present generation of medical men but with the large number of new doctors whose names are being placed on the Medical Register each year. These recently qualified men and women have no voice in the councils of the profession. We do not impugn the motives of the professional organisations when we state that they are inevitably more concerned with the interests of their present members than they are with the needs of future entrants. Most medical men will, henceforward, need to enter the National Health Service in order to make a living. Their path must therefore be made smooth. It is with that special object in mind that this Report is written.

THE MEDICAL STUDENT

AND HIS FUTURE

Some time before qualification the medical student begins to think of his career. Depending upon his inclinations, aptitudes (and still, unfortunately, his financial resources) he will decide into which branch of medicine he wishes to go, and plan accordingly. The class of competition he is likely to meet with is carefully considered, his chances of obtaining the requisite junior hospital appointments estimated and he must learn what eventual reward he is likely to receive in each branch of medicine before he makes a final decision.

Earning power in the two fields

Having weighed the various factors his final decision will be largely influenced by the financial prospects offered to him. Since all specialities in medicine and surgery are to be paid on the same scale he can make a direct comparison between his prospective earnings in the fields of specialisation and general practice. On the one hand specialisation offers him as a start a certain livelihood of £350 per annum as a house officer, rising through the registrar grades (£670 to £1,300) until he is graded as a specialist (£1,700 per annum) at 32 years. His pay will then rise automatically to a maximum of £2,750 per annum at the age of 40. He may hope, if especially brilliant, to add to his salary £500, £1,500 or £2,500 per annum, representing special distinction awards. These figures are all net (his expenses being paid separately).

On the other hand should he enter general practice he may expect to receive £1,000 per annum as an outdoor assistant, out of which he must pay his own car expenses. When he starts on his own he may apply for the fixed annual payment of £300 and his total earnings within the service will henceforward depend upon the number of patients he can attract to his list. Since the average number of patients on the list of a doctor—taking the country as a whole—is 2,500, this figure may be taken for a basis in computing the reasonable earning power of a single-handed practitioner principal. At the present capita-

tion rate of 18/-* he will receive £2,250 per annum gross, but out of this he must pay all his practice expenses (estimated by the Minister of Health to be 35 per cent.) which will leave the average practitioner a net income of £1,465 per annum.† The possible upper limit of his earning power (with a list of 4,000 computed on the same method) is £2,340 net per annum, but it must be noted that—unlike the specialist—for every practitioner who earns more than the average there will be one who will earn correspondingly less.

Comparison of possible earnings

A graded whole-time specialist will receive a net income of £2,750 per annum (minimum) at the age of 40. He will work for set hours and will receive six weeks holiday a year.

The average general practitioner will receive £1,465 per annum net. He is on call 24 hours a day and if he chooses to take six weeks holiday it will cost him £120 in locum's fees, reducing his net income to £1,345 per annum.

The discrepancy between the earnings of the specialist and the general practitioner is enormous and quite out of proportion to the relative value of each to the community. Moreover, the latter, in order to earn the maximum, is required to look after 4,000 patients, which can only mean overwork for himself and inadequate attention for his patients.

The medical student who is considering his future will therefore find the scales heavily weighted in favour of specialisation. He will also be influenced by the fact that as a general practitioner he will have to find a considerable outlay for his car, his surgery premises and his equipment whereas the whole-time specialist has little to provide.

Nevertheless, whatever his inclinations may be, the average medical student will be forced into the field of general practice, because within the Service the number of specialist appointments is bound to be limited, and outside there will be very few posts available.

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* The rate of 18/- is assumed throughout, for this is the sum per head paid into the Central Pool and it must eventually be received in some form or another by the practitioners. The actual rate varies between 14/6 and 17/6, depending upon the number of basic salaries granted and the degree of inflation of the lists. Should a practitioner receive the basic salary, his list is reduced by 1/7th for the purposes of remuneration.

† In certain cases this figure may be increased by various payments not included in the Central Fund.

GENERAL MEDICAL PRACTICE—THE PAST

Before the introduction of the National Health Service there were three possible procedures for the young doctor who wished to enter practice.

(1) He could become an assistant with a view to succession to a partnership.

(2) He could buy a share or the whole of the goodwill of an existing practice.

(3) He could 'put up his plate'.

Each method will be considered separately.

(1) Assistantship with view to partnership

Doctors sometimes ran their practices with a permanent assistant—an arrangement which presumably suited both parties. This, however, was not usual. Normally the assistant wished to secure a share of the goodwill of his principal who, anxious to ensure continuity in his practice (and sometimes to raise capital), took his assistant into partnership. Thus both parties gained by the change.

(2) Buying a practice

The newcomer with sufficient private means or with guarantees could in the past usually obtain money from an insurance company with which to pay cash for his practice, from a building society for his premises and from a finance corporation to buy his motor-car on hire-purchase terms. The young doctor thus started his career by carrying a load of debt, but to counterbalance this he was at least assured of a steady income from which to meet his obligations, and the possession of a saleable capital asset on retirement.

(3) Starting a new practice

There were always a few doctors who preferred to enter practice on their own, choosing to put up their plates in suitable areas. This practice was frowned upon by the established practitioners, for obvious reasons. The method, however, offered some financial advantages to the newcomer, who, provided that he selected his district wisely, could soon make some sort of a livelihood with a comparatively small number of paying patients on his books.

CONDITIONS TODAY ARE VERY DIFFERENT

(1) Assistantship with view to partnership

At the present time little difficulty is experienced by the young doctor in obtaining an assistantship. He will not be long content with this status, however, as it offers him neither security nor certainty of advancement in his earning power.

In the past the principal had two good inducements for taking his assistant into partnership, firstly to ensure continuity in his practice and secondly to raise capital. He can now no longer sell any part of the goodwill of his practice and in making a partner of his assistant feels that he is giving 'something for nothing'. He is also less interested in securing continuity, as he has no longer a list of exacting private patients whose whims it had been politic to humour. The principal, therefore, has every reason to postpone taking his assistant into partnership and the latter thus finds the road to advancement blocked.

(2) Acquiring a practice

A young doctor having completed a period of assistantship is naturally anxious to acquire his own practice. As goodwill cannot be bought or sold and he is unlikely to be offered a partnership, he must wait for a death or retirement vacancy. When such a vacancy is advertised he finds he is in acute competition, often with older and more experienced men. Thus only the fortunate few will succeed in entering practice by this route.

(3) Starting a new practice

In the new Service a doctor can still 'put up his plate', and claim —but is not assured of—the fixed annual payment of £300 per annum, but since his practice takings will come almost entirely from State patients he will need (at present rates of remuneration) to secure a list of at least a thousand before he can even reasonably pay his way. In the past he could secure some sort of livelihood by the acquisition of a few rich patients; now it is numbers that count, and it will presumably take him as long to obtain a thousand State patients as it would in the past to have obtained a thousand paying patients. This method, therefore, even with the salary, is less attractive to the entrant than hitherto.

(1) The responsibility for the provision of General Medical Services lies with the *Local Executive Council.*

'33. (1) (National Health Service Act, 1946)—It shall be the duty of every Executive Council in accordance with regulations to make as respects their area arrangements with medical practitioners for the provision by them as from the appointed day, whether at a health centre or otherwise, of personal medical services for all persons in the area who wish to take advantage of the arrangements, and the services provided in accordance with the arrangements are in this Act referred to as "general medical services".'

(2) These Councils have the powers necessary to enable them to fulfil these above mentioned obligations.

(3) All new entrants to practice, whether assistants or principals, have to apply to the Local Executive Council of the area concerned for permission to practice. On their application form must be stated the surgery address and the hours of attendance.*

(4) This application is forwarded by the Local Executive Council to the Medical Practices Committee for its approval, which may be withheld only if the number of doctors in the particular area has been declared sufficient.

(5) The Medical Practices Committee has the duty of regulating the distribution of practitioners, authorising the admission of practitioners to lists and of approving the filling of practice vacancies.

It follows from the above that any new entrant may practise in any area (i) if that area is not declared 'overdoctored' and (ii) if he gives a surgery address from which to practise.

The fixed annual payment

The new entrant starting practice *de novo* can apply for the fixed annual payment of £300 per annum. He must first be on the list of the Local Executive Council and must be able to show justification why it should be granted.

The present machinery for granting these payments is wholly unsatisfactory. The decision to grant or withhold the payment is made by a local committee which includes interested parties whose incomes are reduced whenever such a payment is made. Each Local Executive Council applies its own standards with the result that there is no common standard for the country as a whole. The decisions on Appeal of the Minister of Health and the Secretary of State for Scotland far from clarifying the position as predicted have made it more confused.

* This is a most unreasonable requirement. The applicant should not be expected to acquire premises before he is certain that (i) he will be allowed to practice and (ii) (if applicable) receive the fixed annual payment.

Entry 'de novo'

Before the new entrant is assured either of permission to practise or of the fixed annual payment he must obtain surgery premises (and presumably somewhere to live). This is no easy matter at the moment. Once installed he must then wait for patients to come to him. In the opinion of the Medical Practitioners' Union he will have to wait a period of one to three years, according to conditions, before he obtains 1,000 patients on his list. His gross income will be £1,070 (including the £300) giving him a spendable income of £695 per annum, which is considerably less than he could obtain as an assistant. He can expect in normal circumstances eventually to raise this figure, as has been stated, to the average net figure of £1,465 per annum. He may even reach the maximum allowed of £2,340 net per annum. Possibly, however, due to circumstances over which he has little control he may fail to attract even 1,000 patients during the first few years, in which case his outlook is bleak indeed.

Conclusion

The Medical Practitioners' Union considers that the new entrant to practice who chooses to 'put up his plate' has relatively poor prospects. Against his expected earnings have to be set the large initial expenses of establishing a practice. These are incurred just at the moment when he can least afford them. The Union can see no reason why a young man or woman who is entering upon a career of public service should be called upon to indulge in a financial gamble. In the past the material risk was slight: now it is considerable and unwarranted.

Since there are so many extraneous factors it would be quite unrealistic to suppose that his or her success depends solely upon the effort and initiative shown. No doctor may advertise—directly or indirectly—his presence in the area, and his eventual success will often depend upon circumstances over which he has little control. The Union has always maintained that the only appropriate method of payment for the doctor is a salary with all expenses paid, and it will continue to press for this, although the Amending Act recently passed by Parliament has added to the difficulty of its attainment.

The following practical recommendations are made in order to improve the lot of the new entrant.

(1) The Medical Practices Committee should become a central employment agency for the supply of doctors to the various branches of the Service. All new entrants, doctors who are unemployed or seeking new fields of practice (both in general and specialist practice) would register their names with the Committee, which should be given the duty of providing suitable openings for these applicants. Conversely the Local Executive Councils and Regional Hospital Boards could apply to the Committee for medical manpower to fulfil their requirements.

(2) The Medical Practices Committee should continue to assess the medical needs of each area into three groups

(*a*) Overdoctored area where no new doctors should be admitted.

(*b*) Averagely doctored areas where new entrants would be allowed but not encouraged.

(*c*) Underdoctored areas where new entrants would be encouraged and actively supported.

(3) In the underdoctored areas new entrants would be financially assisted in three ways.

(*a*) The Local Executive Councils should be empowered to advance money to newcomers for their living expenses and for the purchase of cars, equipment and surgery premises. The sums advanced would be gradually repaid over a long period by suitable deductions from the quarterly cheques.*

(*b*) The Allocation Committees of the Local Executive Councils should make full use of their powers to assist a newcomer in the acquisition of patients.

(*c*) As a corollary the need for the fixed annual payment would be reduced and ultimately disappear.

Succession to Death or Retirement Vacancy

The powers possessed by the Local Executive Councils in connection with death or retirement vacancies are very wide. They can adopt any of the following expedients, with the consent of the Medical Practices Committee.

(1) They may appoint a temporary locum tenens to take care of the practice.

(2) They may decide to abolish the practice as such and redistribute the patients among the other doctors in the area.

(3) They may—but there is no obligation—advertise the vacancy.

(4) They may if they wish acquire the premises of a retiring doctor to secure its use in medical practice.

Most Local Executive Councils advertise such vacancies and they are often inundated with applications. The decision as to whom to appoint rests with the Local Executive Councils (advised by the Local Medical Committees) but the appointment must be confirmed by the Medical Practices Committee.

Suppose for instance that two doctors retire, one with 1,000 patients and the other with 4,000 patients. There are thirty applicants. One will be handed a gross income of £800, another of £3,600 and the remaining twenty-eight will receive nothing. No-one could give an equitable decision in such a matter, which is further complicated by the fact that many doctors (with small lists) already established in the area see no good reason why a newcomer should receive a present of £3,600 a year while they struggle to build up their lists.

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* An alternative suggestion which appealed to some members of Council is to pay an expenses allowance to all general practitioners on the assumption that each practice, whatever its size, has to carry a certain minimum of overhead expenses. Such payments for expenses would become a first charge on the Central Pool.

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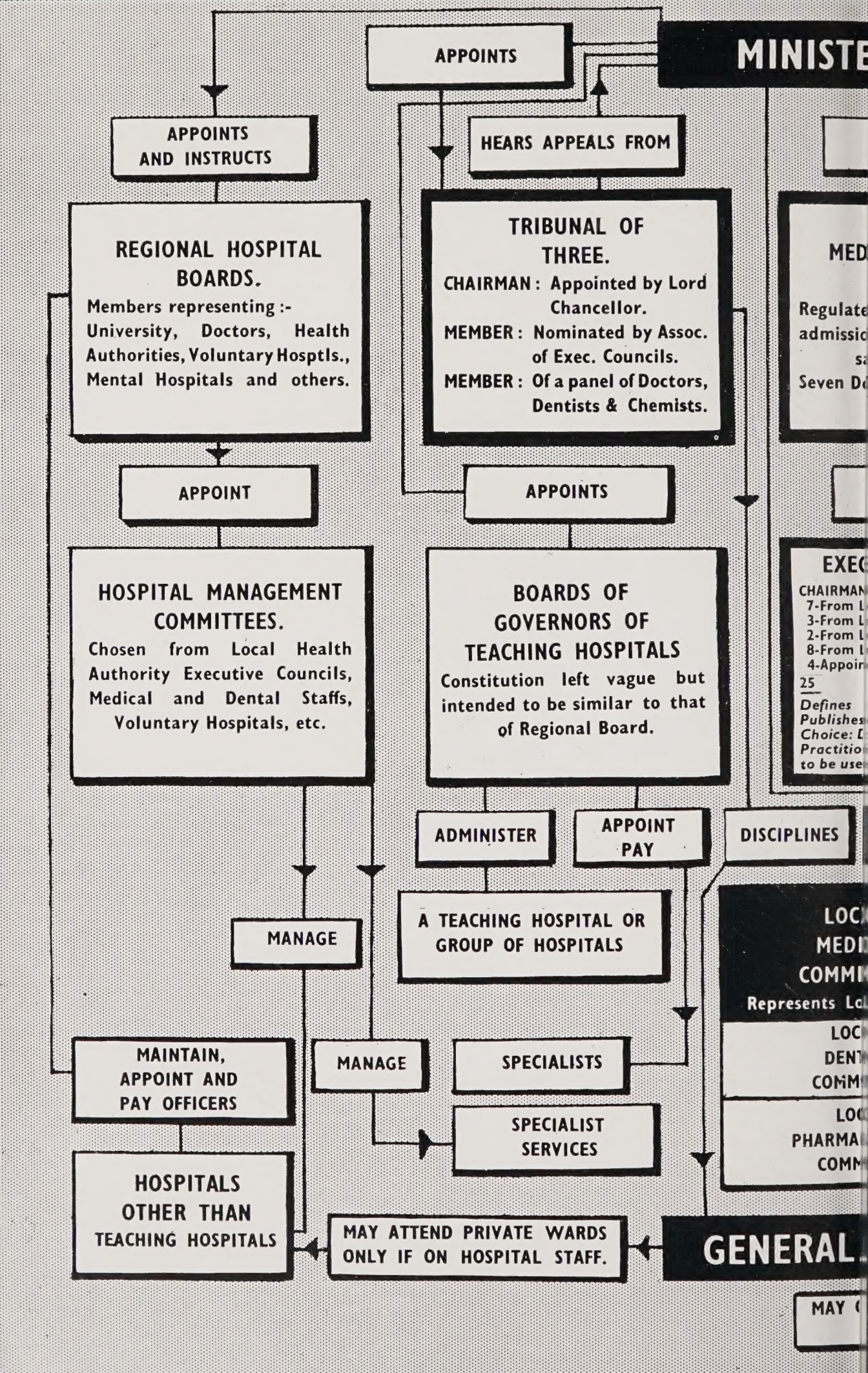

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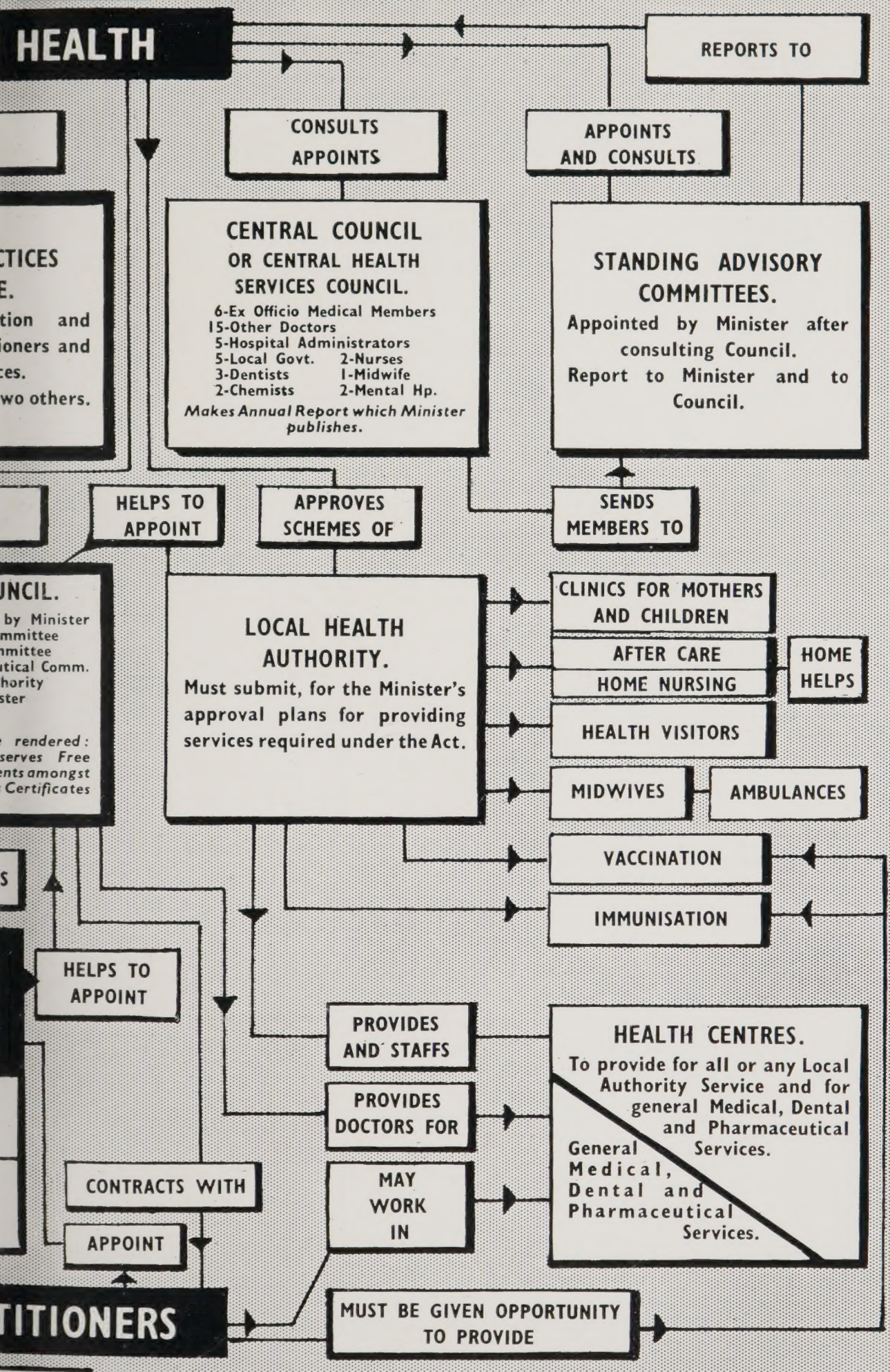

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The complexities of this problem do not end here. Although the thirty applicants are told what income they would receive if chosen, they do not know for certain whether they can acquire the premises of the retiring doctor, which may quite properly be sold by auction to the highest bidder.

Recommendations

The Medical Practitioners' Union recommends that on the death or retirement of a doctor all the patients on his list should be reallocated (by the Allocation Committee) to existing practitioners or newcomers according to the needs of the doctors and the proximity of the patients to their surgeries. (*Examples are given at foot of page*).

The patient would quite rightly maintain his full right to change to another doctor whenever he wished, but experience has shown (over a large number of years) that 95 per cent. of the patients remained on the list of the doctor to whom they were allocated.

The objection put forward to this proposal is that patients, as creatures of habit, would resent having to change surgeries. It is further claimed, with some truth, that many patients are more concerned with the location of the surgery than the identity of the doctor who attends them. There is a strong case for keeping intact a country practice where there are no other surgeries in the immediate neighbourhood, but in the towns such arguments would usually not apply. The new entrant could still acquire the premises of a doctor who retires, but he would not thereby be entitled to the succession of all the patients.

Assistantship with a view to Partnership

Most newly qualified doctors, after a short period as trainee assistants, become full assistants for a time before setting up in practice. This period of assistantship gives them experience of the clinical problems of the practitioners, a familiarity with the forms and procedures of the Health Service and an opportunity to assess the relative advantages of different types of practice.

While appreciating the advantages of the assistantship for a newcomer, the Medical Practitioners' Union considers that a limit should be placed upon the time during which a principal should be able to enjoy the advantages of having an assistant, as it is not in the best interests of the Service for the status of assistantship to be other than temporary.*

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* There may be exceptional cases of old age and illness where the period of two years would be indefinitely extended.

Examples

(1) Dr. A., who has a list of 6,400 with an assistant, in an industrial *underdoctored* area, retires. The list is split up. The assistant is allotted 1,500: three adjacent doctors with small lists are granted 500 extra patients each and the remaining 3,400 patients are allocated between three newcomers when they have found suitable surgery premises in the district. The Local Executive Council could also, if necessary, acquire and rent such premises.

(2) Dr. B., with a list of 4,000 in an *adequately* doctored area, retires. A newcomer who acquired Dr. B's premises would have 1,500 allotted to him the remainder being divided among the existing practitioners.

No young doctor wishes to be tied permanently to working for somebody else. The main reason, however, for advocating a time limit of assistantships is one we have mentioned earlier in the Report, namely, that the principal has no inducement to take his assistant into partnership as long as he is allowed to continue to employ him as an assistant.

Not only should the period of assistantship be limited but the terms and conditions of remuneration of assistants should be laid down. It is not suggested that there should be one rate for all assistants, but there should be established minimum rates for those who are working whole-time in this capacity.

Conclusion

The Medical Practitioners' Union therefore proposes (1) that the period during which a principal could have the benefit of an assistant should normally be limited to two years (at the end of this period he should either take a partner or be required to reduce his list) and (2) that terms of remuneration and conditions of work for assistants should be established.

GROUP PRACTICES AND HEALTH CENTRES

General Practice, and for that matter Consultant Practice, has in the past been on a competitive basis. To obtain the best from the Health Service competition between doctors must give way to co-operation, and the Medical Practitioners' Union would welcome any measure which speeded this transition.

The introduction of a steeply graduated capitation rate would remove the financial necessity for the acute competition for patients which now exists. The old fashioned partnership was designed more to protect the financial interests of the partners than to foster clinical consultation. The financial need for such partnerships has largely disappeared, but the need for group practice remains and has become urgent.

Divorced from its financial context group practice has everything to recommend it. Rota systems for nights and week-ends, mutual consultation between the members and some degree of specialisation within the group would work to the advantage of doctors and patients alike.

The final expression of the co-operative idea will be found in the Health Centres, when built. In these Centres the doctors, thus relieved of many of their present cares, will work in harmony with each other, and with their minds free to devote to their clinical tasks.

Some older doctors, who have spent their professional lives in a competitive system, may not welcome these developments; but the new entrants will at first welcome and later demand such improvements, for realizing that commercial medicine is the enemy of good clinical work, they will resent being launched into the sea of competitive medicine.

In the interests of the medical profession and the public it is vital that group practice shall be encouraged and Health Centres built with the least possible delay.

CHANGING PRACTICES

Not all practitioners once established will wish to spend the remainder of their lives in the same town. After working for years in an industrial town many will wish to move to the country or seaside without actually retiring from practice. No longer can two doctors exchange practices with suitable financial adjustments. Each must obtain the consent of the other's Local Executive Council to enter the area and there can be no absolute certainty of acquiring the practice.

This makes for great rigidity within the Service and unnecessary hardship for the doctors concerned.

The Medical Practitioners' Union proposes that the Medical Practices Committee should act as a bureau for the exchange of practices and that consent should automatically be given.

REMUNERATION OF GENERAL PRACTITIONERS

The Health Service has received a legacy from the old National Insurance Scheme in the shape of the undifferentiated capitation fee. This was an appropriate mechanism of payment when only a small proportion of the practitioner's total earnings were derived from State patients. Now it has become an anachronism. At best the present flat rate is a crude method of distributing payments according to work done. It fails to take into account the relative fixity of practice expenses. When a doctor enters practice he immediately incurs certain expenditure; he must licence and insure his car, he must provide surgery and waiting room accommodation, he must have a telephone and someone to answer it when he is out; he must meet all these charges whether he has 100 or 4,000 patients. The only material increases in practice expenditure he will have to meet as his practice expands are for extra petrol and increased telephone charges.

The newcomer or the established practitioner with a small list is doubly penalised. No account is taken of these overhead expenses in paying him, and for the purposes of superannuation expenses are presumed to represent 35 per cent. of his earnings irrespective of the size of the practice.

One way to correct this anomaly would be to pay an expense allowance to all practitioners on a sliding scale. By this method with less than 1,000 patients one would receive say £500 for expenses, with 1,000—2,000 patients £600, with 2,000—3,000 patients £700 and above £800. These payments would be a first charge upon the Central Fund and the capitation rate would be accordingly reduced.

It must be admitted, however, that such a scheme, although theoretically sound, would be difficult to apply equitably in the lower income range. There are some doctors who from age, inclination or because they still have private practices, wish to restrict their lists to a few hundred, and it would be manifestly unjust to pay them large expense allowances at the expense of their colleagues, or from the public purse.

The Medical Practitioners' Union considers that a graduated capitation rate offers in practice the easiest method of correcting the present anomalies. First proposed by the Union the graduated rate has now been approved by the British Medical Association and the "*Lancet*." Our proposal is that doctors should be paid 30/- a head for the first 2,000 patients and 20/- a head for the remainder; the Association proposes 35/- a head for the first 1,000 and the present capitation rate for the rest. Either scheme would be an improvement upon the present flat rate, but it should be noted that the size of the Central Pool must first be increased so that more money is made available for distribution; otherwise one group would merely benefit at the expense of another.

The graduated capitation rate, if accepted, would go a long way to solve the financial problems of the new entrant to practice.

ENTRY INTO SPECIALIST PRACTICE

When comparing the potential earnings of the young general practitioner and the specialist we assumed that the latter would be appropriately graded and that he would be employed upon a whole-time salaried basis. As matters now exist neither of these assumptions is correct, and it would be fair to say that the future of the aspiring specialist is as uncertain as that of the young man entering general practice. In some respects it is more uncertain, for whereas the latter can be reasonably sure of receiving £1,000 per annum as an assistant the former knows neither how he will be finally graded nor whether there will be a job for him once graded.

The circumstances of the trainee specialist holding a job as a registrar are quite intolerable. There are hundreds of these young men all over the country who are receiving salaries of less than £1,000 per annum as trainee specialists while doing the work of full specialists. This would matter little if they could be sure of promotion in a reasonable period to the full status, but they have no such certainty.

The Assessment Committees of the Regional Hospital Boards, whose function it is to grade the applicants, appear to be influenced by considerations which should not be their concern. It would be impossible otherwise to explain of the very large number who have been relegated to the quite inappropriate grade of Senior Hospital Medical Officers. These include both senior registrars of many years experience, consultants who entered the specialist field from general practice and long established specialists upon the staffs of some of the municipal hospitals.

The nature of these extraneous circumstances can only be guessed at, as the Assessment Committees are anonymous bodies, but it would appear that the members are not anxious to increase the number of full specialists, in spite of the very clear directions issued by the Minister on the subject of grading. Another possible explanation is that these committees have been made aware of the specialist needs of their regions and are loath to grade as specialists more applicants than there will be jobs for. In either case they are at fault, for the assessment of an applicant's standing in the profession should be quite independent of the needs of the Service.

Apart from the question of grading, the young specialist (however graded) does not know whether there is any job open to him, if he is to be employed whole-time or part-time, and if the latter how many sessions a week he will be offered. It is obviously in the interests of the senior established consultant to be employed on a sessional basis for he can thus retain the right to treat private patients and thus 'make the best of both worlds'. The junior consultant, however, will have little opportunity of supplementing his income from private practice and will welcome the offer of a whole-time appointment with the security it offers.

We conclude that the present method of grading should be reviewed and the Regional Hospital Boards instructed to offer whole-time employment wherever possible. We include at the end of this Report some practical recommendations on the subject.

GENERAL CONCLUSIONS

(1) That the medical student now has little or no information to help him make up his mind regarding his future. He knows neither the requirements of the Service in medical manpower in the various branches of medicine nor the remuneration he will receive in each branch.

(2) The recently qualified doctor needs to know precisely what villages, towns, or parts of a town, are in need of more general practitioners.

(3) The present organisation of the general practitioner service tends towards an encouragement of assistantship at the expense of partnership. This is undesirable.

(4) The new entrant has little security and few prospects in general practice.

(5) That the present method of filling vacancies is unfair, and unworkable.

(6) That the method of granting fixed annual payments out of the Local Pool by interested parties, is unjust, is variable from area to area and has proved a failure.

(7) That there is little elasticity in arrangements for changing practices once established.

(8) That the capitation fee now paid is insufficient to give the new entrant the assurance of a livelihood, nor the average practitioner the standard of living he has the right to expect for his special services to the community.
(9) That no general practitioner should be expected to look after the needs of more than 3,000 potential patients.
(10) That a too wide discrepancy exists between the earnings of the general practitioner and the specialist.
(11) That the aspiring consultant has no way of knowing whether his specialist services will be needed; on what basis he will be graded; how many 'sessions' he will be allotted and what his earnings will be.

RECOMMENDATIONS

General Practice

(1) That the Minister should :—
(i) cause to be published yearly an estimate of the requirements of the Service in medical manpower for the ensuing ten years. That these estimates should be in detail in respect to general practitioners and each and every type of specialist.
(ii) ensure that the scale of remuneration paid to general practitioners (*a*) adequately reflects their value to the community (*b*) bears comparison with the remuneration of other professional men in the Health Service and (*c*) includes some mechanism such as the graduated capitation fee to ensure a fair distribution among practitioners of the monies paid into the Central Fund.
(iii) reduce the number of patients which a practitioner may have on his list, by progressive stages over a number of years, from 4,000 to 2,500.
(iv) lay down a scale of minimum remuneration to be paid to an assistant and a locum tenens by principals in practice.
(v) stimulate group practice and use the powers granted to him in the Act to provide Health Centres in which the new entrant to practice should be encouraged to work.

(2) That the Medical Practices Committee should :—
(i) publish at regular intervals a list of those areas which are considered to be underdoctored, adequately doctored and overdoctored;
(ii) undertake the obligation of finding suitable practice vacancies for all those offering their services;
(iii) grant permission to all those wishing to exchange practices to do so subject to proper control;
(iv) be given the power to grant the fixed annual payments to all applicants whose circumstances fall into well defined categories, such payments to be made from the Central Pool, or from a separate fund.

(3) That the Local Executive Councils should :—

(i) be empowered to make advances to new entrants—such advances to be repaid from their earnings;

(ii) make full use of their existing powers to allocate to newcomers and those with inadequate lists suitable numbers of patients;

(iii) cease to transfer vacant practices as units to new entrants. The patients upon the list of a retiring doctor should be allocated to new entrants and to established practitioners with small lists;

(iv) limit to two years the period during which a principal could enjoy the benefits of employing an assistant.

Specialist Practice

(1) The Minister should :—

(i) issue a new directive to the Regional Hospital Boards abolishing the grade of Senior Hospital Medical Officer except in special appropriate circumstances, and requiring the Assessment Committees to apply the Spens recommendations in the grading of trainee specialists.

(ii) require the Regional Hospital Boards to create a medical 'establishment' for every hospital in the country, in which the posts would be filled only by those of the proper grade. The correct beds/specialist ratio should be ascertained and this standard applied in all regions.

(iii) set up a central grading appeals board to which any dissatisfied applicant could appeal;

(iv) instruct the Regional Hospital Boards to offer whole-time post to specialists wherever possible.

The Medical Practitioners' Union is a non-political organisation of medical men and women, which exists to protect the interests of the profession. Its journal, THE MEDICAL WORLD, is published every Friday. Its offices are at 56 *Russell Square, London, W.C.*1, *telephone Museum* 5626-7-8.

Bruce Cardew,
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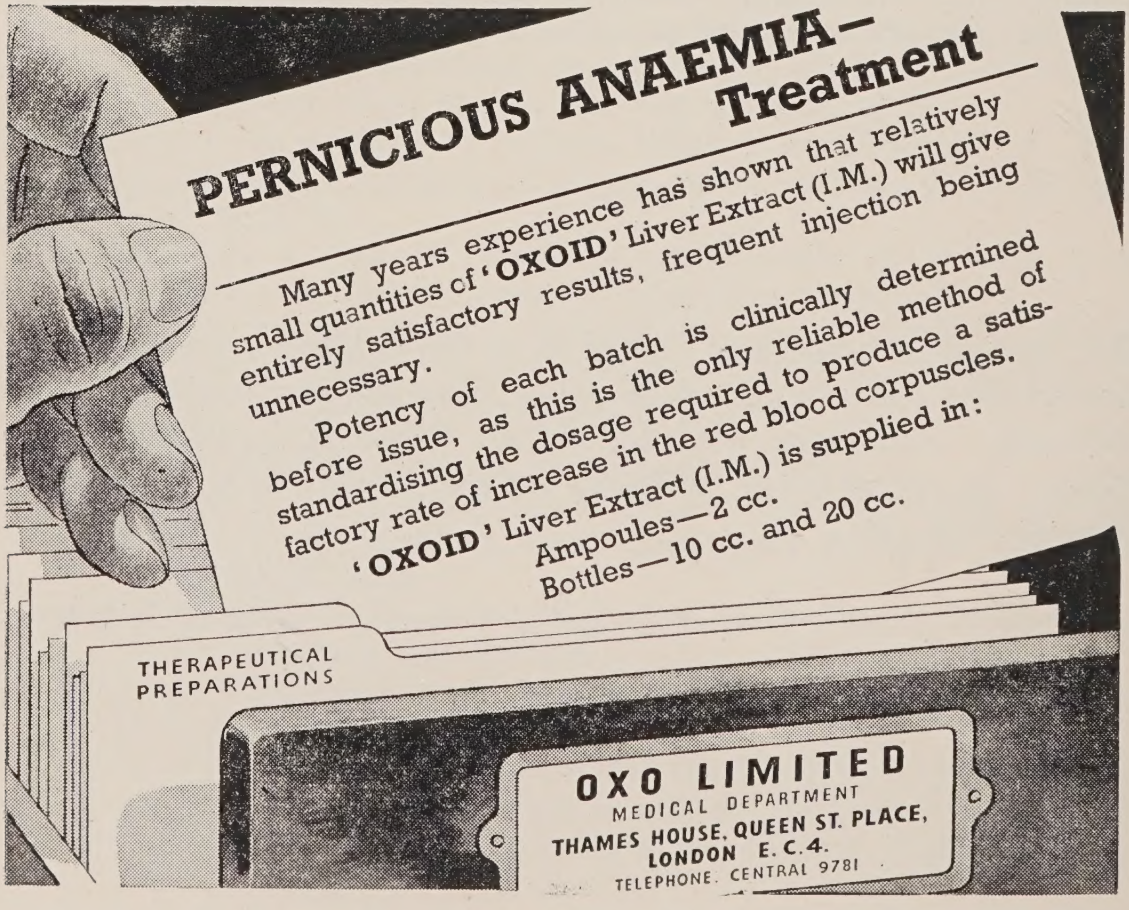

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